

1 STATE OF OKLAHOMA

2 2nd Session of the 60th Legislature (2026)

3 COMMITTEE SUBSTITUTE
4 FOR

5 SENATE BILL 1645

By: Gollihare of the Senate

and

6 Lawson of the House

7
8
9 COMMITTEE SUBSTITUTE

10 An Act relating to the state Medicaid program;
11 defining terms; establishing certain requirements and
12 procedures for audits of providers; directing
13 establishment of certain appeals process; providing
14 for review by administrative law judge; authorizing
15 certain judicial review; prohibiting certain adverse
16 action by the Oklahoma Health Care Authority or a
17 contracted entity; stipulating certain requirements
18 for recoupment of funds; limiting applicability of
19 certain provisions; directing promulgation of rules;
20 providing for codification; and providing an
21 effective date.

22
23
24 BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified
in the Oklahoma Statutes as Section 5051.11 of Title 63, unless
there is created a duplication in numbering, reads as follows:

A. As used in this section:

1. "Audit" means any review, analysis, or investigation
conducted by the Oklahoma Health Care Authority, a contracted

1 entity, or an entity on behalf of the Authority or the contracted
2 entity, of a Medicaid claim submitted by a provider if the review,
3 analysis, or investigation:

4 a. may result in recoupment, withholding, denial, or
5 adjustment of Medicaid payments, and

6 b. involves records, documents, or information other than
7 the filed claim;

8 2. "Capitated contract" and "contracted entity" have the same
9 meanings as provided by the Ensuring Access to Medicaid Act, Section
10 4002.2 of Title 56 of the Oklahoma Statutes;

11 3. "Clerical or recordkeeping error" means a mistake or an
12 omission in the filed claim regarding a required document or record.
13 A clerical or recordkeeping error includes, but is not limited to,
14 a:

15 a. typographical error,
16 b. scrivener's error, or
17 c. computer error; and

18 4. "Provider" means any health care provider or behavioral
19 health provider that is contracted with the Authority or a
20 contracted entity to provide services to members of the state
21 Medicaid program.

22 B. Subject to applicable federal law, when the Oklahoma Health
23 Care Authority or a contracted entity conducts an audit of a
24

1 Medicaid provider, the audit shall be conducted according to the
2 following requirements and procedures:

3 1. The Authority or the contracted entity shall give the
4 provider notice of the audit at least one (1) week before conducting
5 the initial audit for each audit cycle;

6 2. a. An audit that involves the application of clinical or
7 professional judgment shall be conducted in
8 consultation with any state agency that licenses,
9 contracts with, or oversees the provider.

10 b. The Authority or the contracted entity shall not cite
11 a provider that is contracted with a state agency
12 other than the Authority for delivery of Medicaid
13 services for an error based on an act or omission that
14 complied with applicable rules, policies, or guidance
15 of such state agency;

16 3. a. A clerical or recordkeeping error shall not:
17 (1) constitute fraud, or
18 (2) be subject to criminal penalties without proof of
19 intent to commit fraud.

20 b. A claim arising under subparagraph a of this paragraph
21 may be subject to recoupment;

22 4. Submission of a corrected claim by a provider shall not
23 constitute an admission of liability, fault, or wrongdoing;

24

- 1 5. a. When an audit is for a specifically identified problem
2 that has been disclosed to the provider, the audit
3 shall be limited to a claim that is identified by a
4 claim number.
- 5 b. For an audit other than that described in subparagraph
6 a of this paragraph, the audit shall be limited to the
7 greater of:
8 (1) fifty claims, or
9 (2) twenty-five one-hundredths percent (0.25%) of the
10 number of claims billed by the provider to the
11 auditor in the previous calendar year.
- 12 c. If an audit reveals the necessity for a review of
13 additional claims, the audit shall be conducted by one
14 of the following methods at the discretion of the
15 provider:
16 (1) on-site,
17 (2) electronically, or
18 (3) by the same method as the initial audit.
- 19 d. Except for an audit initiated under subparagraph a of
20 this paragraph, the Authority or the contracted entity
21 shall not initiate an audit of a provider more than
22 two (2) times in a calendar year;
- 23 6. A recoupment shall not be based on:
24

1 a. documentation requirements in addition to the
2 requirements for creating or maintaining documentation
3 prescribed by state law or rule or federal law or
4 regulation, or

5 b. a requirement that a provider perform professional
6 duties prescribed by state law or rule or federal law
7 or regulation;

8 7. a. Recoupment shall only occur following the correction
9 of a claim and shall be limited to amounts paid in
10 excess of amounts payable under the corrected claim.

11 b. The Authority or the contracted entity may recoup the
12 entire overpaid claim if payment is issued for the
13 corrected claim on the same date.

14 c. Following a notice of overpayment, a provider shall
15 have at least sixty (60) days to file a corrected
16 claim;

17 8. Approval of a service, provider, or patient eligibility upon
18 adjudication of a claim shall not be reversed unless the provider
19 obtained the adjudication by fraud or misrepresentation of claim
20 elements;

21 9. Each provider shall be audited by the Authority or the
22 contracted entity under the same standards and parameters;

23 10. The Authority or the contracted entity shall disclose to
24 providers all policies, manuals, billing guidelines, and audit

1 criteria and any changes to such policies, manuals, guidelines, and
2 criteria. No recoupment may be based on undisclosed or
3 retroactively applied criteria;

4 11. A provider shall be allowed at least sixty (60) days
5 following receipt of the preliminary audit report in which to
6 produce documentation to address any discrepancy found during the
7 audit;

8 12. The period covered by an audit shall not exceed twenty-four
9 (24) months from the date the claim was submitted to the Authority
10 or the contracted entity;

11 13. a. The preliminary audit report under paragraph 11 of
12 this subsection shall be delivered to a provider
13 within one hundred twenty (120) days after the
14 conclusion of the audit.

15 b. A final audit report shall be delivered to provider
16 within six (6) months after receipt of the preliminary
17 audit report or receipt of the final appeal as
18 provided for in this subsection, whichever is later;
19 and

20 14. Notwithstanding any other provision in this section, the
21 Authority or the contracted entity shall not use the accounting
22 practices of statistical sampling, projection, or extrapolation
23 methodologies to calculate alleged overpayments, recoupments, or
24 penalties for audits.

1 C. 1. The Authority shall establish an appeals process under
2 which a provider may appeal a final audit report to the Authority,
3 and each contracted entity shall adopt the same appeals process. A
4 decision of the Authority or the contracted entity after the appeal
5 shall be final and binding unless a review is requested under
6 paragraph 2 of this subsection.

7 2. Any decision of the Authority or the contracted entity after
8 the appeal shall be subject to review by an administrative law judge
9 designated by the Administrator of the Oklahoma Health Care
10 Authority upon a timely request for review by the applicant or
11 recipient. The Administrator may only designate an administrative
12 law judge at another state agency, as established in the State
13 Medicaid Plan and approved by the Centers for Medicare and Medicaid
14 Services. The designated administrative law judge shall issue a
15 decision after review.

16 3. Any applicant or recipient under this title who is aggrieved
17 by a decision of the designated administrative law judge rendered
18 under paragraph 2 of this subsection may petition the district court
19 in which the provider is located within thirty (30) days of the date
20 of the decision for a judicial review of the decision pursuant to
21 the provisions of Sections 318 through 323 of Title 75 of the
22 Oklahoma Statutes. A copy of the petition shall be served by mail
23 upon the general counsel of the Authority.

24

1 D. The Authority or the contracted entity shall not take
2 adverse action against a provider for exercising rights conferred by
3 this section including, but not limited to, retaliation through
4 selection for additional audits.

5 E. A recoupment of any disputed funds shall only occur after
6 final disposition of the audit, including the appeals processes
7 described in subsection C of this section.

8 F. The total amount of any recoupment on an audit shall be
9 refunded to:

10 1. The contracted entity if the audited services were provided
11 under a capitated contract. The contracted entity shall report such
12 recoupment to the Authority and shall retain, use, or transfer the
13 funds in accordance with rules promulgated by the Oklahoma Health
14 Care Authority Board; or

15 2. If the audited services were provided through the fee-for-
16 service portion of the state Medicaid program:

- 17 a. the state agency responsible for paying the state
18 share of the Medicaid services provided by the
19 provider, if an agency other than the Authority, or
20 b. in the absence of the conditions described in
21 subparagraph a of this paragraph, the Authority.

22 G. This section does not apply to any audit, review, or
23 investigation that involves alleged fraud, willful
24 misrepresentation, or abuse.

1 H. The Oklahoma Health Care Authority Board shall promulgate
2 rules to implement the provisions of this section.

3 SECTION 2. This act shall become effective January 1, 2027.
4

5 60-2-3615 DC 2/17/2026 7:35:49 PM
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24